

CPHRM Authorized Certification - Latest ASHRM Certified Professional in Health Care Risk Management (CPHRM) - CPHRM Premium Exam



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ASHRM CPHRM Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> • Risk Financing: This domain covers managing financial risks through insurance programs, claims coordination, loss analysis, and developing strategies to reduce financial exposure.
Topic 2	<ul style="list-style-type: none"> • Clinical • Patient Safety: This domain focuses on improving patient safety by promoting a safety culture, managing incident reporting, educating staff and patients, addressing ethical concerns, and implementing corrective actions to reduce risks and prevent harm.
Topic 3	<ul style="list-style-type: none"> • Healthcare Operations: This domain involves managing operational risk activities such as conducting risk assessments, developing policies, coordinating risk programs, supervising staff, and supporting patient safety initiatives.
Topic 4	<ul style="list-style-type: none"> • Claims and Litigation: This domain focuses on handling potential claims and legal cases, including claim reporting, litigation support, legal documentation management, and analyzing claims data to understand risk exposure.
Topic 5	<ul style="list-style-type: none"> • Legal and Regulatory: This domain focuses on ensuring compliance with healthcare laws and regulations, protecting patient information, managing reporting requirements, and supporting accreditation and regulatory responses.

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ASHRM Certified Professional in Health Care Risk Management (CPHRM) Sample Questions (Q76-Q81):

NEW QUESTION # 76

Which of the following factors should be considered when setting or adjusting indemnity reserves?

- * incurred medical expenses
 - * emotional pain and suffering
 - * medical expert witness costs
 - * future cost of medical care
-
- A. 2, 3, and 4 only
 - **B. 1, 2, and 4 only**
 - C. 1, 2, and 3 only
 - D. 1, 3, and 4 only

Answer: B

Explanation:

According to Health Care Risk Management principles established by ASHRM and the American Hospital Association Certification Center, indemnity reserves represent the estimated amount the organization expects to pay in settlement or judgment to a claimant. Indemnity refers specifically to damages paid to compensate the injured party, not defense or administrative expenses. Incurred medical expenses are a core component of economic damages and must be included in indemnity reserve calculations. Emotional pain and suffering fall under non-economic damages and are also considered when estimating potential settlement or verdict value. Future cost of medical care is another essential factor, particularly in cases involving long-term injury or disability, as it represents projected economic damages that may substantially increase exposure. Medical expert witness costs, however, are categorized as defense expenses and are typically included in allocated loss adjustment expenses rather than indemnity reserves. These costs relate to the defense of the claim rather than compensation to the plaintiff. Risk management objectives emphasize accurate differentiation between indemnity and expense reserves to ensure proper financial reporting and regulatory compliance. Therefore, incurred medical expenses, pain and suffering, and future medical costs should be considered when setting indemnity reserves, while expert witness costs should not.

NEW QUESTION # 77

An organization has recently changed insurance. The risk manager receives a claim from a former patient on July 3, 2004, claiming injury and alleging negligence by the surgery staff on September 5, 2003. Which of the following would apply to this claim?

- * a claims-made policy for the period 1/1/03 to 1/1/04 with a retro date of 1/1/02
 - * an occurrence policy for the period 1/1/03 to 1/1/04
 - * a claims-made policy for the period 1/1/03 to 1/1/04 with a 1-year tail coverage
 - * an occurrence policy for the period 1/1/04 to 1/1/05
-
- A. 1 and 2 only
 - B. 1 and 4 only
 - **C. 2 and 3 only**
 - D. 3 and 4 only

Answer: C

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, coverage determination depends on both the policy trigger and relevant dates. The alleged negligence occurred on September 5, 2003. Under an occurrence policy in effect from 1/1/03 to 1/1/04, coverage applies because the event occurred during that policy period, regardless of when the claim was filed. Therefore, option 2 applies. For a claims-made policy covering 1/1/03 to 1/1/04, coverage would require that the claim be made and reported during the policy period unless tail coverage is in place. Because the claim was received on July 3,

2004, after expiration of the 1/1/03 to 1/1/04 claims-made policy, coverage would apply only if a 1-year tail was purchased. Thus, option 3 applies.

Option 1 would not apply because the claim was made after the claims-made policy period ended, and no tail is specified. Option 4 would not apply because occurrence coverage from 1/1/04 to 1/1/05 would not cover an event that occurred in 2003.

Risk financing objectives emphasize understanding policy triggers, reporting requirements, and tail coverage.

Therefore, the applicable coverage scenarios are the occurrence policy for 2003 and the claims-made policy with tail coverage.

NEW QUESTION # 78

What factors are included in a calculation of Risk Priority Number (RPN) in FMEA?

- A. Cost, staff satisfaction, marketing risk
- B. Legal privilege, media attention, reputation
- C. Severity, occurrence (probability), detection
- D. Insurance premiums, deductibles, coinsurance

Answer: C

Explanation:

In Failure Modes and Effects Analysis (FMEA), the Risk Priority Number (RPN) is commonly calculated as the product of three ratings: Severity (S) of impact, Occurrence (O) likelihood/probability, and Detection (D) ability to detect the failure before it causes harm (lower detectability increases risk). This structured scoring helps teams prioritize which failure modes deserve immediate mitigation. Risk management objectives include proactively identifying high-risk process steps (medication administration, specimen labeling, surgery scheduling), designing controls (standard work, forcing functions, redundancy), and tracking residual risk after changes. While cost and feasibility may influence selection of mitigations, they are not the core RPN elements. Using S-O-D improves transparency in prioritization, supports interdisciplinary alignment, and provides a defensible rationale for resource allocation toward patient safety improvements.

NEW QUESTION # 79

If a practitioner requests a telemedicine consult with another practitioner in another state, the consultant:

- A. May need to hold a valid license in the patient's state (requirements vary by state)
- B. Can practice under the patient's insurance plan only
- C. Can rely on verbal permission from the ED nurse
- D. Never needs any license

Answer: A

Explanation:

Telemedicine licensure is largely state-based in the U.S., and many states require the consulting clinician to be licensed in the state where the patient is located (with exceptions such as specific compacts, special telehealth registrations, or emergency provisions). Risk management objectives include verifying licensure /credentialing before services, ensuring privileging-by-proxy processes where applicable, confirming malpractice coverage for telehealth and cross-state practice, and ensuring informed consent/privacy safeguards. Failure to comply can trigger regulatory penalties, payer issues, and liability exposure if care is delivered without proper authorization.

NEW QUESTION # 80

A hospital has opted to open an anticoagulation clinic. As this is a high-risk medication, a risk manager wants to conduct a risk assessment before opening the clinic. The BEST tool to use would be a

- A. root cause analysis RCA.
- B. failure mode and effects analysis FMEA.
- C. cause and effect diagram.
- D. scatter diagram.

Answer: B

Explanation:

Failure Mode and Effects Analysis FMEA is the most appropriate tool in this scenario because it is a proactive risk assessment

methodology designed to identify and mitigate potential failures before harm occurs. According to Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, FMEA is specifically used when introducing new processes, services, or high-risk clinical operations, such as an anticoagulation clinic involving medications with narrow therapeutic indices and significant bleeding risks.

FMEA systematically evaluates each step in a proposed process, identifies possible failure modes, analyzes their causes and effects, and prioritizes risks using severity, occurrence, and detectability scoring. This structured approach aligns with patient safety objectives by reducing preventable adverse events before implementation.

In contrast, Root Cause Analysis RCA is a retrospective tool used after an adverse event has occurred. A cause and effect diagram is a component often used within RCA or FMEA but is not a comprehensive risk assessment tool on its own. A scatter diagram is primarily used for statistical correlation analysis and does not evaluate process failures.

Therefore, for proactive risk identification and mitigation prior to clinic opening, FMEA is the best and most appropriate tool.

NEW QUESTION # 81

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